APPLICATION FOR LICENSURE FOR MEDICAL LABORATORY

FOR ADMINISTRATIVE USE ONLY Date Received _____

Amount _____

I. IDENTIFICATION

Name of Laboratory _____

Address _____
STREET

_____
CITY COUNTY ZIP CODE

Telephone Number _____

Director's Name _____

Level of Education _____

Date laboratory began operation at present address _____

Date laboratory began operation under present Director _____

I. CONTROL (Circle one in each column)

State	Profit	Individual
County	Nonprofit	Partnership
City		Corporation
Private		

A. If laboratory is operated by an individual or partnership, complete the following information on the individual or partners:

Name: _____

_____

_____

_____

B. If laboratory is operated by a corporation, complete the following:

Name of corporation _____

State where incorporated _____

Address _____

_____

President or Chairman _____

Vice President _____

Treasurer _____

C. If laboratory is owned by other than the persons listed in A or B above, complete the following: (i.e., Parent Corp., County/State owned, etc.)

Name of Owner _____

Address of Owner _____

_____

D. Service (Check appropriate box)

- ☐ Microbiology
  - ☐ Bacteriology
  - ☐ Mycology
  - ☐ Parasiteology
  - ☐ Virology
- ☐ Serology
- ☐ Chemistry
  - ☐ Urinalysis
- ☐ Immunohematology
  - ☐ Blood Group & RH Typing
  - ☐ Antibody Detection & Titers
- ☐ Pathology
  - ☐ Tissue
  - ☐ Oral
  - ☐ Diagnostic Cytology
- ☐ Hematology
- ☐ Radiobioassay
- ☐ Histocompatibility

Others: Specify Below

_____

II. I agree that this laboratory and all aspects of its operation shall be open at all times to the inspection and surveillance of all state agency licensure and certification personnel.

III. I certify that the information given in completing this application is accurate to the best of my knowledge and recognize that falsification of this application can result in denial of license.

_____ _____

Date Signature of Authorized Representative

Licensure Fee Per Laboratory: Initial $155.00
Renewal $80.00

Make check or money order payable to Treasurer. **PLEASE DO NOT SEND CASH.**

Please return completed form to: Cabinet for Health Services
Office of Inspector General
275 E. Main St., 5E-A
Frankfort, Kentucky 40621